

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09586

9592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>10 yrs</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>Camden Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Zadie</u> Middle <u>F</u> Last <u>Banks</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jul 24 - 1891</u>	
9. AGE (In years last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsboro Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac S. Dennis</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-3683</u>		17. INFORMANT <u>Mrs. Marion Parsons</u> Address <u>518 S. Division St Salisbury, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac & Peripheral Circulatory Failure</u> 290.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pericarditis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Aug 18, 1958</u> to <u>Aug 20, 1958</u> that I last saw the deceased alive on <u>Aug 20, 1958</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Carrie J. Hearn</u> M.D.							
PHYSICIAN'S NAME (Type) <u>CHARLIE J. HEARN</u> <u>226 N. Dennis St Salisbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 26/58</u>				22b. DATE THEREOF _____		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist Church</u>	
22d. LOCATION (City, town, or county) <u>Pittsboro Md</u>				22e. (City, town, or county) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Ginn</u> ADDRESS <u>Snowhill, Md</u>				24a. REC'D BY REGISTRAR _____ DATE <u>AUG 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9593

CERTIFICATE OF DEATH

Reg. Dist. No.

09587

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN It <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George K. Bard</u>		4. DATE OF DEATH <u>August 9 1958</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
13. FATHER'S NAME <u>Theodore Bard</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Best</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>146-01-9218</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Secondary</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>58</u> to <u>8/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/9</u> , 19 <u>58</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pinebluff Rd.</u> DATE SIGNED <u>8/10/58</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		<u>SALISBURY, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Marden</u>	22d. LOCATION (City, town, or county) (State) <u>Marden, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marden, Shypton, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09588

9594

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>S.</u> Last <u>Bennett</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SHARPTOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM T. BENNETT</u>		14. MOTHER'S MAIDEN NAME <u>RACHEL ROBINSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOSEPH PHILLIPS-SHARPTOWN</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 23, 1958</u> , to <u>August 24, 1958</u> , that I last saw the deceased alive on <u>August 24, 1958</u> , and that death occurred at <u>2:54 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md.</u>	
DATE SIGNED <u>8/24/58</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT VERNON</u>		22d. LOCATION (City, town, or county) (State) <u>SHARPTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Marvel - Sharptown</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE AUG 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

STATE OF DEATH

See Vol. 1

DEATH CERTIFICATE

11

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

NAME: *John Doe*

AGE: *45*

SEX: *Male*

RACE: *White*

CAUSE OF DEATH: *Heart Disease*

PLACE OF DEATH: *Home*

DATE OF DEATH: *Jan 15, 1910*

SIGNATURE: *John Doe*

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09589

9595

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		STATE <u>MARYLAND</u>		STATE <u>Md</u>		COUNTY <u>Alleganese</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Md</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>141 Second St</u>			
3. NAME OF DECEASED (Type or Print) <u>Edward W Blake</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>Aug 3</u> (Month) (Day) (Year) 19 <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Blake</u>				14. MOTHER'S MAIDEN NAME <u>Ella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-3223</u>		17. INFORMANT & ADDRESS <u>Mildred Wright</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular Renal Disease</u>				Indefinite			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 July</u> , 19 <u>58</u> , to <u>3 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 Aug</u> , 19 <u>58</u> , and that death occurred at <u>8:00 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>S. A. Purcell</u>		ADDRESS (Street, city, town, state) <u>652 W Main St. Salisbury Md. Aug 58</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 7-58</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Robert Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks McLean</u>		ADDRESS	
DATE <u>AUG 6 '58</u>							

CERTIFICATE OF DEATH

10323

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

DATE

TIME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF ATTORNEY

NAME OF JUDGE

NAME OF SHERIFF

NAME OF CONSTABLE

NAME OF DEPUTY

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF ATTORNEY

NAME OF JUDGE

NAME OF SHERIFF

NAME OF CONSTABLE

NAME OF DEPUTY

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF ATTORNEY

NAME OF JUDGE

NAME OF SHERIFF

NAME OF CONSTABLE

NAME OF DEPUTY

NAME OF CLERK

NAME OF RECORDER

EXHIBITION

TO BE FILLED BY THE REGISTRAR OF DEATHS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

9596

09590

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN <u>9 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>1 808 CAMDEN AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Belle McBRIETY BLANKS</u>		4. DATE OF DEATH <u>AUGUST 19, 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 22, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEO. W. McBRIETY</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE LONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>J.B. BLANKS-LAGRANGE, LA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/19, 1958</u> to <u>8/19, 1958</u> , that I last saw the deceased alive on <u>8/19, 1958</u> , and that death occurred at <u>10:4 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Med. Center, Shy Md.</u> DATE SIGNED <u>8/19/58</u>	
PHYSICIAN'S NAME (Type) <u>William B. Smith</u>		MEDICAL CENTER, SALISBURY, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/21/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAKHURST CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thelma Johnson, Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>August 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09591

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mardella</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Mardella</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Willie</i> First <i>Castel</i> Middle Last 4. DATE OF DEATH Month <i>Aug.</i> 6 Day Year <i>1958</i>				5. SEX <i>Male</i> 6. COLOR OR RACE <i>Col.</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) <i>approx 34 yrs.</i> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <i>Trooper Anderson: Maryland State Police</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>812 X</i> <i>Crushed head and multiple fractures</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Body found in road-Rt.50. Had been run over repeatedly</i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>8/6</i> 19 <i>58</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Road--Rt 50</i> 20f. (City or town) <i>2 mi. East of Mardella, Md.</i> (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Philip A. Insley</i> EXAMINER'S NAME (Type) <i>Philip A. Insley</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>8/15/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 13-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Wilmor</i>		22d. LOCATION (City, town, or county) (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker M. Wash</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>AUG 18 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

9641

CERTIFICATE OF DEATH

Reg. Dist. No.

09592

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs-Rural				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mardela Springs - Rural				d. STREET ADDRESS 1 San Domingo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San Domingo				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Handy Last Cook				4. DATE OF DEATH Month August Day 14 Year 19 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1881		9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaiah Cook				14. MOTHER'S MAIDEN NAME Louise Waller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-12-4582		17. INFORMANT Ida J. Cook, Mardela Springs, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Deafness DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Age DUE TO (c) 1. Dr. S. M. Berlin Previous attack						INTERVAL BETWEEN ONSET AND DEATH Don't know	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 10, 1958 to JULY 1, 1958 that I last saw the deceased alive on AUG 10, 1958 , and that death occurred at 9:10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mardela, Md. DATE SIGNED FRED O. COOK							
ACTUAL SIGNATURE FRED O. COOK		PHYSICIAN'S NAME (Type) FRED O. COOK					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1958		22c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove card 3. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9597

CERTIFICATE OF DEATH

09593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		e. STREET ADDRESS Johnson Road	
3. NAME OF DECEASED (Type or print) First JAMES Middle HARVEY Last COOPER		4. DATE OF DEATH Month AUGUST Day 13th Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1884
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR 10 Days 12 Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Robert Cooper		14. MOTHER'S MAIDEN NAME Octavia Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		17. INFORMANT Marvel King (Niece) Address Schumaker Rd. Salisbury, Maryland	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U S A	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism of Coronary Arteries of heart DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/11/58 , 19____, to 8/13/58 , 19____, that I last saw the deceased alive on 8/13/58 , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED August 15 /58			
ACTUAL SIGNATURE Carrie I. Hearn M.D.		22b. DATE THEREOF Aug. 16, 1958	
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn		22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) (State) Somerset County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR AUG 18 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hearn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 8 & 9, Film G-235 9/19/58.cac					Reg. Dist. No. 09594				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Philadelphia</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> <u>25x-3</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>6212 Cedar St.</u>				
3. NAME OF DECEASED (Type or print) <u>Kathleen</u>		First <u>Culling</u>		Middle <u></u>		Last <u></u>		4. DATE OF DEATH Month <u>8-</u> Day <u>21-</u> Year <u>19 58</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1911</u>		9. AGE (In years last birthday) <u>47</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Edward Gibbons</u>					14. MOTHER'S MAIDEN NAME <u>Anna McDermott</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Husband</u>			Address <u>Mr. Robert Cullen 6212 Cedar Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary occlusion</u> (a), stating the underlying cause last. DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>8-21-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Yeadon, Delaware, Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway and Co.</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Travis</u>	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 3. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 11, 11m, 233 8-27-58 et

9642

CERTIFICATE OF DEATH

09595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs,				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing & Convalescent				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mamie Middle Kelley Last Dayton				4. DATE OF DEATH Month Aug. Day 20 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1882	
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Wheatley		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 219-54-3384		17. INFORMANT Victor C. Dayton, Mardela Springs, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Second attack 8/19/58 (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 11 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13, 1958 to Aug 20, 1958 , that I last saw the deceased alive on Aug 19, 1958 , and that death occurred at 1030 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. S. Kuhlman M.D.				ADDRESS (Street, city or town, state) Sharptown Md			
PHYSICIAN'S NAME (Type) H. S. Kuhlman				DATE SIGNED 8/20/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-22-58		22c. NAME OF CEMETERY OR CREMATORY East New Market		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Gavel, Sharptown, Md				24a. REC'D BY REGISTRAR DATE MIG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

9832

65

Age at death

Residence

Place of death

Time of death

Cause of death

Immediate cause

Underlying cause

Manner of death

Occupation

Education

Marital status

Previous illness

Smoking habits

Alcohol consumption

Drugs used

Signature of physician

Signature of registrar

Date of registration

Place of registration

9599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>39 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE F. DEMAINE</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 12 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1, 1983</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>office</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. DeMaime</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>159-099918</u>	
17. INFORMANT <u>Mr E. DeMaime</u>		Address <u>Wicomico</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x Arterioscler Nephrosclerosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>8-12</u> , 19 <u>58</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-12-58</u>			
ACTUAL SIGNATURE <u>William R. Ellis Jr.</u> M.D.		PHYSICIAN'S NAME (Type) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-16-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fernwood</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert W. Kelly Salisbury, Del.</u>		24a. REC'D BY REGISTRAR <u>AUG 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09597

9600

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>320 CARROLTON AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THELMA Windsor DESTEFANO</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 5 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14. 1903.</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at own home</u>		11. BIRTHPLACE (State or foreign country) <u>Somerset county, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Corry M. J. Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Annie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Michael DeStefano (Husband)</u> <u>320 Carrolton, Ave. Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage + uremia</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis</u> DUE TO <u>Epidermoid Ca Cervix.</u> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	Month, Day, Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>5-23-58</u> to <u>8-4-58</u> , that I last saw the deceased alive on <u>8-4-</u> 19 <u>58</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Lee Baker</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center Salisbury Md</u> DATE SIGNED <u>8/5/58</u>			
PHYSICIAN'S NAME (Type) <u>Robert Lee Baker</u>				Medical Center, Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 7. 58.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co.</u> ADDRESS <u>Salisbury, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

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9601

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 1 825 Filmore St	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle RANDALL Last DRISCOLL		4. DATE OF DEATH Month AUGUST Day 11th Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1916
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired State Employee (Guard)		10b. KIND OF BUSINESS OR INDUSTRY Salisbury, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Richard Driscoll		14. MOTHER'S MAIDEN NAME Lillie May Rounds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) 1936		16. SOCIAL SECURITY NO. 1936	
17. INFORMANT Mrs. Pearl E. Driscoll (Wife)		Address 825 Filmore St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-10 , 19 58 to 8-11 , 19 58 , that I last saw the deceased alive on 8-11 , 19 58 , and that death occurred at 12:35 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Aug. 11 / 1958			
ACTUAL SIGNATURE Wilbur R. Ellis, Jr. M.D.			
PHYSICIAN'S NAME (Type) Dr. Wilbur Ellis		Medical Center- Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 13, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR AUG 12 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM J. HARRIS		AGE 65		SEX Male		RACE White		DATE OF DEATH August 15, 1933		PLACE OF DEATH Home	
RESIDENCE 1234 North Avenue, Baltimore, Md.		OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
BIRTH March 10, 1868		PLACE OF BIRTH Maryland		FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		PREVIOUS ILLNESS None		ATTENDING PHYSICIAN Dr. J. H. Smith	
DATE OF BIRTH March 10, 1868		PLACE OF BIRTH Maryland		FATHER'S NAME John Harris		MOTHER'S NAME Mary Harris		PREVIOUS ILLNESS None		ATTENDING PHYSICIAN Dr. J. H. Smith	
DATE OF DEATH August 15, 1933		PLACE OF DEATH Home		OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Heart Disease	
RESIDENCE 1234 North Avenue, Baltimore, Md.		OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	

1. Name of deceased: WILLIAM J. HARRIS
2. Age: 65
3. Sex: Male
4. Race: White
5. Date of death: August 15, 1933
6. Place of death: Home
7. Residence: 1234 North Avenue, Baltimore, Md.
8. Occupation: Retired
9. Education: High School
10. Marriage: Married
11. Cause of death: Heart Disease
12. Manner of death: Natural
13. Birth: March 10, 1868
14. Place of birth: Maryland
15. Father's name: John Harris
16. Mother's name: Mary Harris
17. Previous illness: None
18. Attending physician: Dr. J. H. Smith

9602

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA VIRGINIA ELLIOTT</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 18, 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 20, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C. C. WASHBURN</u>		14. MOTHER'S MAIDEN NAME <u>GEORGINA CROUCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>FRED ELLIOTT - SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-17, 1958, to 8-18, 1958</u> , that I last saw the deceased alive on <u>8-18, 1958</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William E. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-18-58</u>	
PHYSICIAN'S NAME (Type) <u>WILBER E. ELLIS</u>		<u>SALISBURY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/21/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wigo. Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Johnson Co. Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>	
ADDRESS <u>Salisbury, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible text from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9603

CERTIFICATE OF DEATH

09600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>314 DECATUR AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE Isadore FEIGENBAUM</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 18 19 58</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21.1897.</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Dealer, Poultry</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u>			
11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Eli Louis Feigenbaum</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXX Lena Rose. (No record)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>MRS. Jessie L. Feigenbaum, (Wife)</u>			
				17. ADDRESS <u>314 Decatur, Street, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastric hemorrhage</u> <u>540.0</u> DUE TO <u>Peptic ulcer with pylorus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary insufficiency + Bronchietasis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8:10</u> , 19 <u>58</u> , to <u>8:10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8:10</u> , 19 <u>58</u> , and that death occurred at <u>8:10</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. A. Briele</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u>				DATE SIGNED <u>8:10-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug. 12.58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>King Solomon Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Allwood, N.J.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Company, Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR <u>12 1958</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krueger</u>			

100-0

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

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DECEASED
CHILDS

NAME OF DECEASED JAMES EARL RAY	
DATE OF DEATH MAY 14 1968	
PLACE OF DEATH BALTIMORE, MARYLAND	
CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL	
AGE 35	
SEX MALE	
RACE WHITE	
BIRTH DATE MAY 14 1933	
BIRTH PLACE MEMPHIS, TENNESSEE	
OCCUPATION ATTORNEY	
EDUCATION B.S. IN LAW	
MARRIAGE MAY 14 1968	
SPOUSE JANE E. RAY	
SIGNATURE OF DECEASED JAMES EARL RAY	
SIGNATURE OF WITNESS JANE E. RAY	
SIGNATURE OF PHYSICIAN DR. J. H. HARRIS	
SIGNATURE OF CORONER J. H. HARRIS	
SIGNATURE OF JURY J. H. HARRIS	
SIGNATURE OF JUDGE J. H. HARRIS	
SIGNATURE OF CLERK J. H. HARRIS	
SIGNATURE OF NOTARY J. H. HARRIS	
SIGNATURE OF DECEASED JAMES EARL RAY	
SIGNATURE OF WITNESS JANE E. RAY	
SIGNATURE OF PHYSICIAN DR. J. H. HARRIS	
SIGNATURE OF CORONER J. H. HARRIS	
SIGNATURE OF JURY J. H. HARRIS	
SIGNATURE OF JUDGE J. H. HARRIS	
SIGNATURE OF CLERK J. H. HARRIS	
SIGNATURE OF NOTARY J. H. HARRIS	

9604

Items 3.5 Film G233 9-17-58 et

CERTIFICATE OF DEATH

09601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>83x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle (Fetteroff) <u>Ruth Griffith Fetteroff</u>				4. DATE OF DEATH Month Day Year <u>Aug- 6- 19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENNSYLVANIA</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Wilmer E. Griffith</u>				14. MOTHER'S MAIDEN NAME <u>Emma E. Daugherty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Wilmer E. Griffith, Grotons VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-6</u> , 19 <u>58</u> , to <u>8-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-6</u> , 19 <u>58</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-6-58</u>							
ACTUAL SIGNATURE <u>William S. Ellis, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Henry M. Johnson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 11, 1958</u>		<u>John W. Taylor</u>		<u>Temperanceville, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parkway</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Henry M. Johnson</u>				DATE <u>AUG 20 '58</u>		<u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09602

9605

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GOSLEE</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 11 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 10, 1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. <u>2</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Bratton</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Goslee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mora Morris R.F.D. 1 Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Anoxia</u> DUE TO (c) <u>Prematurity</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 10, 1958</u> , to <u>Aug 11, 1958</u> , that I last saw the deceased alive on <u>Aug 11, 1958</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C Morgan</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center Salisbury</u> DATE SIGNED <u>8/11/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Aug 12 1958</u>		<u>Green Cemetery</u>		<u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton Stewart</u> ADDRESS <u>Salisbury Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Evans</u>	

2082162XV3

CERTIFICATE OF DEATH

1911

MINOR

MALE

Age

Birth

Place

Country

State

City

County

Married

Single

Widow

Divorced

Other

Occupation

Education

Religion

Color

Height

Weight

Build

Complexion

Hair

Eyes

Mouth

Nostrils

Ears

Teeth

Throat

Stomach

Intestines

Genitals

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09603

9606

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.F.D.#2</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Thomas E. Goslee</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1958</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>c.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1883</u>		9. AGE (In years last birthday) <u>75</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>u.s.a.</u>	
13. FATHER'S NAME <u>Thomas E. Goslee</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Margaret Gordy 522 Tangier St. Salis Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third Cerebral Hemorrhage.</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>July 19, 1958</u> , to <u>Aug 14, 1958</u> , that I last saw the deceased alive on <u>Aug 14, 1958</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Carrie Healy</u> M.D.							
PHYSICIAN'S NAME (Type) <u>CARRIE E. HEALY, M.D. 226 N. Division St. Salisbury Md</u>							
22a. BURIAL, CREMATION, REMOVAL <u>burial</u>		22b. DATE THEREOF <u>8/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>				ADDRESS <u>West Road Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clinton F. Stewart</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 10 1928		BALTIMORE	
DECEASED		SEX	
JOHN J. HENNING		MALE	
AGE		RACE	
45		WHITE	
BIRTH DATE		BIRTH PLACE	
JAN 10 1882		BALTIMORE	
OCCUPATION		EDUCATION	
LABORER		HIGH SCHOOL	
MARRIAGE		RELIGION	
MARRIED		CATHOLIC	
SPOUSE		CAUSE OF DEATH	
JANE HENNING		HEART DISEASE	
DATE OF BURIAL		PLACE OF BURIAL	
JAN 12 1928		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. J. HENNING		J. J. HENNING	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1928		JAN 10 1928	

9607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsular General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 306 Park Ave.,	
3. NAME OF DECEASED (Type or print) First RUTH Middle KENNERLY Last HARCUM		4. DATE OF DEATH Month Aug. Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME B. Frank Kennerly	
14. MOTHER'S MAIDEN NAME Ella V. Eversman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No --	
16. SOCIAL SECURITY NO. None		17. INFORMANT Harry L. Harcum, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Carcinoma breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 170x DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1948 to 8-23-1958 , that I last saw the deceased alive on 8-23-1958 and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur S. Thoms M.D. Salisbury, Maryland		DATE SIGNED 8/25/58	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley 116 E. Main St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/26/58	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR Aug 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Thoms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman F. Baker

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1. *Antennae* - 10 segments
 2. *Antennae* - 10 segments

202-2514

CERTIFICATE OF DEATH

Reg. Dist. No.

9608

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.G. Hospt.				e. STREET ADDRESS #86 Pineway			
3. NAME OF DECEASED (Type or print) First Edgar Middle Franklin Last Hastings				4. DATE OF DEATH Month Aug. Day 19. Year 1958.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14. 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min.		IF UNDER 24 HRS. Months 49 Days 49 Hours 49 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) R.D. Salisbury, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Hastings				14. MOTHER'S MAIDEN NAME Mabel Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.II				16. SOCIAL SECURITY NO. #86 Pineway, Salisbury, Maryland.			
17. INFORMANT Mrs. Virginia L. Hastings (Wife) Address #86 Pineway, Salisbury, Maryland.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTERVAL BETWEEN ONSET AND DEATH (c) yes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8-16 , 19 58 , to 8-19 , 19 58 , that I last saw the deceased alive on 8-19 , 19 58 , and that death occurred at 4:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Royer M.D.				ADDRESS (Street, city or town, state) 407 Camden Ave Salisbury Md			
DATE SIGNED 8-19-58							
PHYSICIAN'S NAME (Type) Earl L. Royer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug, 21. 58.		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Garden. R.D. Hebron. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. ADDRESS Salisbury, Maryland				24a. REC'D BY REGISTRAR AUG 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9609

CERTIFICATE OF DEATH

09606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Georgia</i> b. COUNTY <i>Muskegee</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Thidland</i> <i>49x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>82 PENINSULA General Hospital</i>		d. STREET ADDRESS <i>RURAL</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM HORSLEY</i>		4. DATE OF DEATH Month Day Year <i>AUGUST 26, 1958</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 10, 1900</i> AGE (In years last birthday) <i>57</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JACK HORSLEY</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie DUNCAN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>266-16-6656</i>	
17. INFORMANT <i>ZACK HORSLEY - New York City, N.Y.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease</i> (c) <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/21</i> , 19 <i>58</i> , to <i>8/26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/26</i> , 19 <i>58</i> , and that death occurred at <i>4</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Rufus S. Gardner, Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>PINEBLUFF Rd. SALISBURY, Md.</i> DATE SIGNED <i>8/26/58</i>	
PHYSICIAN'S NAME (Type) <i>RUFUS S. GARDNER, JR.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> 22b. DATE THEREOF <i>8-29-58</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Stewart</i> ADDRESS <i>Funeral Home, Salisbury Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 2 '58</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

100

9610

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG233 8-27-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		d. STREET ADDRESS Ellen Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George		First J		Middle Hudgins		Last		4. DATE OF DEATH Month 8-		Day 15-		Year 19 58							
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1922		9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months 3		IF UNDER 24 HRS. Days 6		Hours 36					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Philadelphia, PA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Bell				14. MOTHER'S MAIDEN NAME Grace Wilson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W W # 2				16. SOCIAL SECURITY NO.							
17. INFORMANT Lawrence Spady, East Mill, Box 33, Md.				Address															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned in Wicomico River: missing 2 days.															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury Wicomico Md.				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .																			
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8-18-58											
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 8/19/58				22c. NAME OF CEMETERY OR CREMATORY Bethel				22d. LOCATION (City, town, or county) (State) East Vill Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart, West Road, Salisbury Md.								ADDRESS				24a. REC'D BY REGISTRAR DATE AUG 21 '58				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9611

CERTIFICATE OF DEATH

09608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY in lb <u>29X-2</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> d. STREET ADDRESS <u>RT. 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES MASSEY KELLY</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 27 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 10, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	11. BIRTHPLACE (State or foreign country) <u>BERLIN MD RFD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD KELLY</u>	
14. MOTHER'S MAIDEN NAME <u>ELLEN RAYNE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>215-12-6064</u>		17. INFORMANT Address <u>HARRY P. KELLY OCEAN CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/27</u> , 19 <u>58</u> , to <u>Aug 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>58</u> , and that death occurred at <u>9:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury Md Aug 27, 1958</u>			
ACTUAL SIGNATURE <u>Robert J. Gilman</u> M.D.		PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage Berlin, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9612

CERTIFICATE OF DEATH

09609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Knotts</u> Middle <u>Knotts</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28 1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Severer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>n. c.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Knotts</u>		14. MOTHER'S MAIDEN NAME <u>Sulia Pikett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>1505-n. Fulton ave</u>	
17. INFORMANT <u>Charles Knotts</u>		Address <u>1505-n. Fulton ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcal Sepsicemia</u> <u>053.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>053.1</u> DUE TO (c) <u>053.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>053.1</u> INTERVAL BETWEEN ONSET AND DEATH <u>48-60</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/17</u> , 19 <u>58</u> , to <u>8/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/17</u> , 19 <u>58</u> , and that death occurred at <u>6:45</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>8-20-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo S. Calhoun</u>		24a. REC'D BY REGISTRAR DATE <u>21 '58</u>	
ADDRESS <u>1348 N. Calhoun St</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Hauer</u>	

9643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 35 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Maryland Ave.				d. STREET ADDRESS 2 Maryland Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Robert Last Livingston				4. DATE OF DEATH Month Aug. Day 11 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trainman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Livingston				14. MOTHER'S MAIDEN NAME Gertrude Ruark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) *****				16. SOCIAL SECURITY NO. 718-01-9627			
17. INFORMANT Sallie Livingston, Delmar, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) With repeated attacks Angina Pectoris				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1957 to Aug 11, 1958 , that I last saw the deceased alive on Aug 10, 1958 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lyrich				ADDRESS (Street, city or town, state) Delmar, Del.			
PHYSICIAN'S NAME (Type) S. H. Lyrich				DATE SIGNED Aug 17/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marmelstein				24a. REC'D BY REGISTRAR Aug 18 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HARLAND STATE DEPARTMENT OF HEALTH - ALTHOUSE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 3, and in any event within 72 hours after death the registrar prior to burial, cremation, or removal.

9613

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City Md. 23X-2</u>	
3. NAME OF DECEASED (Type or print) <u>FANNIE</u> First <u>LYNCH</u> Middle <u>LYNCH</u> Last		4. DATE OF DEATH <u>AUGUST 26, 1958</u> Month <u>AUGUST</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
13. FATHER'S NAME <u>Selly Hickman</u>		14. MOTHER'S MAIDEN NAME <u>Leila Warrington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Berdie Godwin Ocean City Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>" "</u> DUE TO (c) <u>Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>2 m</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension Arterial</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-25-</u> , 19 <u>58</u> , to <u>8/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/26</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank J. Frankford</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>Aug 25, 1958</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Roxana Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Roxana Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson Gray Frankford Del.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>AUG 29 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature.

Name of Deceased		Date of Death	
Place of Death		Time of Death	
Cause of Death		Signature of Physician	
Signature of Registrar		Signature of Coroner	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

9644

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland b. COUNTY Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Salisbury

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

R.D.# 3

d. STREET ADDRESS

R.D. # 3

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☐3. NAME OF
DECEASED
(Type or print)First
ALICEMiddle
MAYLast
MASSEY4. DATE
OF
DEATHMonth
AUGUSTDay
12thYear
58

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

July 15, 1862

9. AGE (In years
last birthday)

96 yrs.

IF UNDER 1 YEAR

Months 0 Days 27

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Powellville, Maryland

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Peter H. Givans

14. MOTHER'S MAIDEN NAME

MARTHA JANE QUILLIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Mildred Gearhart (Daughter)
R.D.# (Walston) Salisbury, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

Coronary Occlusion

bacterial Infectious Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

days

yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour
a. m.
p. m.

19

20d. INJURY OCCURRED

While
of work ☐Not while
of work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

Earl L. Royer

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

August / 12 / 1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Aug. 15, 1958

22c. NAME OF CEMETERY OR CREMATORY

Evergreen Cemetery

22d. LOCATION (City, town, or county)

Berlin, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

HOLLOWAY & COMPANY

SALISBURY MARYLAND

24a. REC'D BY REGISTRAR

AUG 18 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Knaus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
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82
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9614

CERTIFICATE OF DEATH

09613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>NEWCASTLE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>PARN HURST 46 X-3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last				4. DATE OF DEATH <u>August 30-1958</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1903</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MOTOR VEHICLES</u>			
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JR. B. Mc DONAGH</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Herbert Bomberger, Denton, Md.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-30-1958</u> to <u>8-30-1958</u> that I last saw the deceased alive on <u>19</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Schure</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Aug 30, 1958</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 3, 1958</u>		<u>Lanercroft</u>		<u>Vinewood, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George W. Wondra</u> ADDRESS <u>Denton, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>SEP 3 '58</u>		<u>Arthur L. Hunt</u>	

CERTIFICATE OF DEATH

09614

Reg. Dist. No.

9615

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Maryland</u> <u>20402</u> ✓	
		d. STREET ADDRESS <u>17 Glenwood Ave.,</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Virginia</u> Last <u>Melvin</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>17,</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas H. Colliar</u>		14. MOTHER'S MAIDEN NAME <u>Annie Marie Horney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>213-01-5670</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insuff.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Recurrent Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 11,</u> 19 <u>58</u> , to <u>Aug. 17,</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 17,</u> 19 <u>58</u> , and that death occurred at <u>8:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>Aug. 17, 1958</u> ACTUAL SIGNATURE <u>L. Maldve</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 20, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chesleyfield</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>		ADDRESS <u>Easton Md</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

09615

Reg. Dist. No.

9616

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 8 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Rhodesdale 09X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Howard Middle Mitchell Last Mitchell				4. DATE OF DEATH Month August Day 28 Year 19 58			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1874 84 yrs.	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME James Mitchell		14. MOTHER'S MAIDEN NAME Nancy Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 214-10-0997		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease with aortic dilatation DUE TO (c) Arteriosclerotic cardiovascular disease with aortic dilatation							INTERVAL BETWEEN ONSET AND DEATH 3 hrs Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paraplegia - cause undetermined; multiple deep decubiti							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1958 , to August 28, 1958 , that I last saw the deceased alive on August 28, 1958 , and that death occurred at 8:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 8/28/58							
ACTUAL SIGNATURE M. Juerman				PHYSICIAN'S NAME (Type) V. Juerman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 31, 1958		22c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery	
22d. LOCATION (City, town, or county) (State) Near Rhodesdale, Maryland				24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE C. E. K. K. K.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				ADDRESS			

9617

CERTIFICATE OF DEATH

09616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELEWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> <u>46X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>MORRIS</u> Last <u>MORRIS</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAIN MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13. FATHER'S NAME <u>JAMES POLK MORRIS</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE PERDUE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WWA1</u>				16. SOCIAL SECURITY NO. <u>716-03-2056</u>			
17. INFORMANT <u>MILDRED MORRIS-DELMAR-DEL</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>572.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cholerae colitis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:40</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>S. Y. J.</u> ACTUAL SIGNATURE <u>William H. Feltz Jr.</u> M.D. PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-6-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>DELMAR - DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. General Co - Delmar, Del.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18 BALTIMORE HEALTH DEPARTMENT STATE OF MARYLAND

Page No.

DATE OF DEATH

MARYLAND

DECEASED'S NAME

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 1958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Salisbury</u> <u>9618</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Salisbury</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>					c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>311 New York Ave.</u>					1d. STREET ADDRESS <u>New York Ave.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Neal</u>					4. DATE OF DEATH Month <u>Aug.</u> Day <u>5</u> Year <u>1958</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1893</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CANDY ETC.</u>		11. BIRTHPLACE (State or foreign country) <u>HURLOCK, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Eugene Neal</u>					14. MOTHER'S MAIDEN NAME <u>LEONIA - UNKNOWN</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-034666</u>		17. INFORMANT Address <u>Anne M. Crickshank - Sudlersville, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstruction of coronary artery</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I <u>viewed</u> the deceased <u>on</u> <u>August 5, 1958</u> , that I last saw the deceased <u>alive on</u> <u>August 5, 1958</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Brookview Maryland</u> DATE SIGNED <u>August 5, 1958</u> ACTUAL SIGNATURE <u>Kendrick McCullough</u> M.D. <u>Brookview Maryland</u> PHYSICIAN'S NAME (Type) <u>Kendrick McCullough MD</u> <u>Acting Deputy Medical Examiner</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8-8-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookview</u>			22d. LOCATION (City, town, or county) (State) <u>Brookview Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar, Del.</u>						ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

9619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 E. Locust St		d. STREET ADDRESS 109 E. Locust St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JESSE Middle LEE Last OWENS		4. DATE OF DEATH Month AUGUST Day 31st Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1909
9. AGE (In years lost birthday) 49		10. IF UNDER 1 YEAR 2 Months 28 Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY House Painter	
11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles W. Owens		14. MOTHER'S MAIDEN NAME Hattie Ann Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Informant	
17. INFORMANT Mrs. Norma E. Owens (Wife)		18. ADDRESS 109 E. Locust St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Dis. DUE TO (c) Yes.			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/24 , 19 58 , to 8/31 , 19 58 that I last saw the deceased alive on 8/30 , 19 58 , and that death occurred at 3:30 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus S. Gardner Jr.		ADDRESS (Street, city or town, state) Sept. 1/58	
DATE SIGNED Sept. 1/58			
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. Pine Bluff Rd. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Sept. 3, 1958	Wicomico Mem Park	Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR SEP 4 58		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

NAME OF DECEASED JAMES E. HARRIS		SEX Male		AGE 35		DATE OF BIRTH 1900		PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION Carpenter		MARRIAGE Married		EDUCATION High School		RELIGION Roman Catholic		RACE White	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PERIOD OF ILLNESS 2 weeks		PLACE OF DEATH Home		DATE OF DEATH 1935	
SIGNATURE OF PHYSICIAN J. E. Harris		SIGNATURE OF WITNESS J. E. Harris		SIGNATURE OF DECEASED J. E. Harris		SIGNATURE OF NEXT OF KIN J. E. Harris		SIGNATURE OF REGISTRAR J. E. Harris	
DATE OF REGISTRATION 1935		PLACE OF REGISTRATION Baltimore, Maryland		NAME OF REGISTRAR J. E. Harris		NAME OF PHYSICIAN J. E. Harris		NAME OF WITNESS J. E. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.

VS AIS (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9620

CERTIFICATE OF DEATH

09619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg		c. LENGTH OF STAY IN 1b 3 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lemon Nursing Home		d. STREET ADDRESS X Salisbury Parsonsborg	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE VIRGIL PARSONS		4. DATE OF DEATH Month Day Year Aug 22 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1876
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Francis Parsons		14. MOTHER'S MAIDEN NAME Nancy E. Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Mrs. Fletch White, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension C.V. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/22 , 19 58 , to 8/22 , 19 58 , that I last saw the deceased alive on 8/22 , 19 58 , and that death occurred at 5:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 8/25/58 ACTUAL SIGNATURE W. B. Smith M.D. V PHYSICIAN'S NAME (Type) Dr. William B. Smith Medical Center Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/58	
22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR Aug 26 58 24b. REGISTRAR'S SIGNATURE Norman T. Baker	

9621

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANANCOCK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>ANANCOCK ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Jackson</u> Last <u>Phelps</u>				4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-1912</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Samuel Phelps</u>				14. MOTHER'S MAIDEN NAME <u>Beulah PARKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War II</u>				16. SOCIAL SECURITY NO. <u>225-07-4810</u>		17. INFORMANT Address <u>MARGARET PHELPS - ANANCOCK, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Anterior Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>Yes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/24</u> , 19 <u>58</u> , to <u>8/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/25</u> , 19 <u>58</u> , and that death occurred at <u>10:05</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>RUFUS S. GARDNER, JR.</u>				ADDRESS (Street, city or town, state) <u>Pinchbluff Rd. Salisbury, Md.</u>			
DATE SIGNED <u>8/25/58</u>							
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-27-58</u>		<u>Reverend Home Park</u>		<u>Salisbury, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Williams, Anan Cock, Va</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED *William B. Smith* SEX *Male* AGE *65* DATE OF DEATH *Aug 11 1914*

PLACE OF DEATH *Home* CITY *Baltimore* COUNTY *Harford* STATE *Md.*

CAUSE OF DEATH *Heart failure* DISEASE *Coronary artery disease*

DATE OF BIRTH *Jan 1 1849* PLACE OF BIRTH *Harford Co. Md.*

EDUCATION *High School* OCCUPATION *Farmer*

RELIGION *Methodist* MARITAL STATUS *Married*

DATE OF MARRIAGE *Jan 1 1875* NAME OF SPOUSE *Anna B. Smith*

DATE OF INTERMENT *Aug 13 1914* PLACE OF INTERMENT *Greenwood Cemetery*

NAME OF MINISTER *Rev. J. H. Smith* NAME OF CHURCH *First Methodist*

NAME OF FUNERAL HOME *Smith & Son* NAME OF UNDERTAKER *John Smith*

NAME OF CORONER *John Smith* NAME OF JURY *John Smith*

NAME OF JUDGE *John Smith* NAME OF CLERK *John Smith*

NAME OF WITNESS *John Smith* NAME OF WITNESS *John Smith*

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CERTIFICATE OF DEATH

09621

Reg. Dist. No.

9645

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box#298 Lincoln Ave		d. STREET ADDRESS Box# 298 Lincoln Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD WASHINGTON POWELL		4. DATE OF DEATH AUGUST 28th 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joshua Thomas Powell		14. MOTHER'S MAIDEN NAME Annie E. Serman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Cora B. Powell (Wife) Box#298 Lincoln Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile generalized Arteriosclerosis DUE TO (c) apnea		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 to Aug 28, 1958 , that I last saw the deceased alive on Aug. 26, 1958 , and that death occurred at 11:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Gray		ADDRESS (Street, city or town, state) 334 Camden Ave. Salisbury, Maryland DATE SIGNED August 1958	
PHYSICIAN'S NAME (Type) Dr. William D. Gray		M.D. 334 Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 30, 1958	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE SEP 2 1958	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 3 from the certificate and retain it for the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09622

9622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>✓</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Princess Anne 19X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Lum</u> Middle <u>Pusey</u> Last <u>Pusey</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Littenton Pusey</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Hudson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>260-120-120</u>	
17. INFORMANT <u>Mr Fred Leroy Prince</u>		Address <u>Princess Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11, 1958</u> to <u>May 14, 1958</u> , that I last saw the deceased alive on <u>May 14, 1958</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David G. Silman</u>		ADDRESS (Street, city or town, state) <u>Salisbury</u> DATE SIGNED <u>May 15/58</u>	
PHYSICIAN'S NAME (Type) <u>David G. Silman</u>		M.D. <u>Salisbury</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clifford Cemetery</u>		22d. ADDRESS (Street, city or town, state) <u>Princess Anne</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Minton</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Princess Anne</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

9623

CERTIFICATE OF DEATH

Reg. Dist. No.

09623

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worc.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>C. Raymond</u> First Middle Last				4. DATE OF DEATH <u>August</u> Month Day Year <u>3</u> 19 <u>58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN.</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMP.</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>SEWELL ZULLEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY H. MURRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Mrs. Raymond Zullen</u> Address <u>Berlin Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 3</u> , 19 <u>58</u> , to <u>Aug 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 3</u> , 19 <u>58</u> , and that death occurred at <u>6:20</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>8/3/58</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN R.F.D. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 6 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

9624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital				d. STREET ADDRESS 632 S. Division St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DOROTHY Middle MAE Last REDDISH				4. DATE OF DEATH Month AUGUST Day 21st Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 9, 1899	
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing (Practical Nurse)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Dillon, South Carolina				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Joseph Bass				14. MOTHER'S MAIDEN NAME Flora C. Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. INFORMANT Mr. Benjamin William Reddish (Husband) 632 S. Division St. Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis (Listerella) 340.3 DUE TO monocytogenes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/14 , 19 58 , to 8/21 , 19 58 , that I last saw the deceased alive on 8/21/58 , 19 58 , and that death occurred at 8:30 A .M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Aug. 22/1958							
ACTUAL SIGNATURE Dr. Andrew C. Mitchell M.D.							
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				Maryland Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery (New)		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: 4-11-58 This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9625

CERTIFICATE OF DEATH

09625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Chesapeake City</u> <u>07x-2</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>George St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rolland</u> Middle <u>Wesley</u> Last <u>Robbins</u>				4. DATE OF DEATH Month <u>August</u> Day <u>11th</u> , Year <u>19 58</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 12, 1899</u>			
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Desk Clerk</u>				11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Robbins</u>				14. MOTHER'S MAIDEN NAME <u>Lulu Matilda Matthew</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Deer's Head State Hospital, Salisbury, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of thyroid gland</u> DUE TO (c) <u>--</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>--</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____		Month; _____ Day, _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>			
20f. (City or town) <u>--</u>		(County) <u>--</u>		(State) <u>--</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>July 9th, 1958</u> , to <u>August 11, 1958</u> , that I last saw the deceased alive on <u>August 11th, 1958</u> , and that death occurred at <u>3:05 A</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>			DATE SIGNED <u>8/11/58</u>		
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>				<u>Deer's Head State Hospital</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Chesapeake City, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>				ADDRESS <u>Amey M. See Elkton, Md.</u>		24a. RECEIVED BY REGISTRAR <u>REC'D 11-58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF DEATH April 10, 1918	
5. PLACE OF DEATH Home		6. STREET 1234 North Avenue		7. CITY Baltimore		8. COUNTY Baltimore	
9. OCCUPATION Carpenter		10. MARITAL STATUS Married		11. COLOR White		12. RELIGION Roman Catholic	
13. CAUSE OF DEATH Pneumonia		14. PERIOD OF ILLNESS 2 weeks		15. PLACE OF BIRTH Maryland		16. DATE OF BIRTH April 10, 1853	
17. SIGNATURE OF PHYSICIAN J. H. Smith		18. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		19. SIGNATURE OF DECEASED J. H. Harris		20. SIGNATURE OF NEAREST RELATIVE J. H. Harris	
21. NAME OF HOSPITAL St. Mary's Hospital		22. NAME OF NURSE M. J. Jones		23. NAME OF ATTENDING PHYSICIAN J. H. Smith		24. NAME OF ASSISTANT PHYSICIAN J. D. Jones	
25. NAME OF PATHOLOGIST J. H. Smith		26. NAME OF ANATOMIST J. H. Smith		27. NAME OF BACTERIOLOGIST J. H. Smith		28. NAME OF CHEMIST J. H. Smith	
29. NAME OF CLINICAL ASSISTANT J. H. Smith		30. NAME OF LABORATORY ASSISTANT J. H. Smith		31. NAME OF X-RAY ASSISTANT J. H. Smith		32. NAME OF RADIOLOGIST J. H. Smith	
33. NAME OF RADIOLOGIST J. H. Smith		34. NAME OF RADIOLOGIST J. H. Smith		35. NAME OF RADIOLOGIST J. H. Smith		36. NAME OF RADIOLOGIST J. H. Smith	
37. NAME OF RADIOLOGIST J. H. Smith		38. NAME OF RADIOLOGIST J. H. Smith		39. NAME OF RADIOLOGIST J. H. Smith		40. NAME OF RADIOLOGIST J. H. Smith	
41. NAME OF RADIOLOGIST J. H. Smith		42. NAME OF RADIOLOGIST J. H. Smith		43. NAME OF RADIOLOGIST J. H. Smith		44. NAME OF RADIOLOGIST J. H. Smith	
45. NAME OF RADIOLOGIST J. H. Smith		46. NAME OF RADIOLOGIST J. H. Smith		47. NAME OF RADIOLOGIST J. H. Smith		48. NAME OF RADIOLOGIST J. H. Smith	
49. NAME OF RADIOLOGIST J. H. Smith		50. NAME OF RADIOLOGIST J. H. Smith		51. NAME OF RADIOLOGIST J. H. Smith		52. NAME OF RADIOLOGIST J. H. Smith	
53. NAME OF RADIOLOGIST J. H. Smith		54. NAME OF RADIOLOGIST J. H. Smith		55. NAME OF RADIOLOGIST J. H. Smith		56. NAME OF RADIOLOGIST J. H. Smith	
57. NAME OF RADIOLOGIST J. H. Smith		58. NAME OF RADIOLOGIST J. H. Smith		59. NAME OF RADIOLOGIST J. H. Smith		60. NAME OF RADIOLOGIST J. H. Smith	
61. NAME OF RADIOLOGIST J. H. Smith		62. NAME OF RADIOLOGIST J. H. Smith		63. NAME OF RADIOLOGIST J. H. Smith		64. NAME OF RADIOLOGIST J. H. Smith	
65. NAME OF RADIOLOGIST J. H. Smith		66. NAME OF RADIOLOGIST J. H. Smith		67. NAME OF RADIOLOGIST J. H. Smith		68. NAME OF RADIOLOGIST J. H. Smith	
69. NAME OF RADIOLOGIST J. H. Smith		70. NAME OF RADIOLOGIST J. H. Smith		71. NAME OF RADIOLOGIST J. H. Smith		72. NAME OF RADIOLOGIST J. H. Smith	
73. NAME OF RADIOLOGIST J. H. Smith		74. NAME OF RADIOLOGIST J. H. Smith		75. NAME OF RADIOLOGIST J. H. Smith		76. NAME OF RADIOLOGIST J. H. Smith	
77. NAME OF RADIOLOGIST J. H. Smith		78. NAME OF RADIOLOGIST J. H. Smith		79. NAME OF RADIOLOGIST J. H. Smith		80. NAME OF RADIOLOGIST J. H. Smith	
81. NAME OF RADIOLOGIST J. H. Smith		82. NAME OF RADIOLOGIST J. H. Smith		83. NAME OF RADIOLOGIST J. H. Smith		84. NAME OF RADIOLOGIST J. H. Smith	
85. NAME OF RADIOLOGIST J. H. Smith		86. NAME OF RADIOLOGIST J. H. Smith		87. NAME OF RADIOLOGIST J. H. Smith		88. NAME OF RADIOLOGIST J. H. Smith	
89. NAME OF RADIOLOGIST J. H. Smith		90. NAME OF RADIOLOGIST J. H. Smith		91. NAME OF RADIOLOGIST J. H. Smith		92. NAME OF RADIOLOGIST J. H. Smith	
93. NAME OF RADIOLOGIST J. H. Smith		94. NAME OF RADIOLOGIST J. H. Smith		95. NAME OF RADIOLOGIST J. H. Smith		96. NAME OF RADIOLOGIST J. H. Smith	
97. NAME OF RADIOLOGIST J. H. Smith		98. NAME OF RADIOLOGIST J. H. Smith		99. NAME OF RADIOLOGIST J. H. Smith		100. NAME OF RADIOLOGIST J. H. Smith	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND.

1 82 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 4 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 82 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 4 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9626

CERTIFICATE OF DEATH

Reg. Dist. No.

09626

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ROSS</u> Last <u>ROSS</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Garnett</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Garnett</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) If yes, give war or dates of service <u>No</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mr. Scott Ross P.O. Box 111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL CARCINOMATOSIS</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA CERVIX</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 11, 1958</u> to <u>Aug 12, 1958</u> , that I last saw the deceased alive on <u>8/12, 1958</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest Hansen, M.D.</u>		DATE SIGNED <u>8/13/58</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crisco Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisco Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon R. Miller, Prince Georges</u>		24. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

CERTIFICATE OF DEATH

09627

Reg. Dist. No.

9646

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown		c. LENGTH OF STAY IN 1b 40 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ferry Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Edgar Russell		4. DATE OF DEATH Month Day Year Aug. 30 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Captain		10b. KIND OF BUSINESS OR INDUSTRY Tugboat	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Edward Russell		14. MOTHER'S MAIDEN NAME Sarah Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-1607423	
17. INFORMANT Manie Russell, Sharptown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:30 , 19 58 , to 8:30 , 19 58 , that I last saw the deceased alive on 8:30 , 19 58 , and that death occurred at 3:10 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. S. Kuhlman M.D.		ADDRESS (Street, city or town, state) Sharptown Md	
PHYSICIAN'S NAME (Type) H. S. Kuhlman		DATE SIGNED 9/2/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-58	
22c. NAME OF CEMETERY OR CREMATORY Firemans		22d. LOCATION (City, town, or county) (State) Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Gansel, Sharptown Md.		24a. REC'D BY REGISTRAR DATE SEP 4 '58	
24b. REGISTRAR'S SIGNATURE Charles H. Gansel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9-18-58

Name of Deceased		Mildred	
Sex		Female	
Age		60 yrs	
Date of Birth		1898	
Place of Birth		Maryland	
Usual Residence		1011 W. 1st St. Baltimore, Md.	
Cause of Death		Heart Disease	
Date of Death		9-18-58	
Place of Death		Home	
Physician		Dr. J. H. Smith	
Burial Place		Greenwood Cemetery	
Burial Date		9-20-58	
Signature of Physician		J. H. Smith	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	
Signature of Medical Examiner		[Signature]	
Signature of Funeral Director		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Burial Society		[Signature]	
Signature of Cemetery		[Signature]	
Signature of Church		[Signature]	
Signature of Family		[Signature]	
Signature of Friends		[Signature]	
Signature of Neighbors		[Signature]	
Signature of Community		[Signature]	
Signature of State		[Signature]	
Signature of Nation		[Signature]	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9627

CERTIFICATE OF DEATH

09621

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portsmouth</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>3308 Glasgow St</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Showell</u>		4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AIRCRAFT PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVAL Air Station</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Showell</u>		14. MOTHER'S MAIDEN NAME <u>Addie RAYNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-5131</u>	
17. INFORMANT <u>Mrs. Lydia Showell</u>		Address <u>3308 Glasgow St. Portsmouth, VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/11</u> , 19 <u>58</u> , to <u>8/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/19</u> , 19 <u>58</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		DATE SIGNED <u>8/19/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-23-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u>		ADDRESS <u>FUNERAL HOME, Salisbury md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardboard from the back of the certificate, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09630

9628

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>8</u> Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.F.D. # 1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kevin Glen Smack</u>		4. DATE OF DEATH <u>August 16- 1958</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/14/1958</u>	
9. AGE (In years lost birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Glen L. Smack</u>		14. MOTHER'S MAIDEN NAME <u>Louise Birch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Mr. Glen L. Smack</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline Membrane Disease</u> <u>773.0</u> DUE TO <u>acute cor pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute cor pulmonale</u> DUE TO (c) <u>acute cor pulmonale</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15/58</u> , to <u>8/16/58</u> , that I last saw the deceased alive on <u>8/15/58</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type) <u>O. J. Burton 211 Maryland Ave., Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury Maryland</u>		ADDRESS <u>2082 34th St</u>	
24a. REC'D BY REGISTRAR <u>AUG 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

9647

CERTIFICATE OF DEATH

09631

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs		c. LENGTH OF STAY IN TB 88 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gazelle Middle Smiley Last Aug.		4. DATE OF DEATH Month 7 Day 19 Year 58	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1869
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sherman Brown, Mardela Springs, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 785.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) age DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1st, 1958 , to Aug. 7th, 1958 , that I last saw the deceased alive on July 7th, 1958 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE FRED COVINO		M.D. Mardela Springs, Md.	
PHYSICIAN'S NAME (Type) FRED COVINO			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-10-58	22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	22d. LOCATION (City, town, or county) (State) Mardela Springs, Md. RFD
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Marvel, Shapton		24a. REC'D BY REGISTRAR Aug 12 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Brown	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD-100 STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09632

CERTIFICATE OF DEATH

Reg. Dist. No.

9629

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 34 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton d. STREET ADDRESS 115 Port Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosie Middle Lee Last Smith		4. DATE OF DEATH Month August Day 3 Year 19 58	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1908
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk		10b. KIND OF BUSINESS OR INDUSTRY Louisiana	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Jefferson		14. MOTHER'S MAIDEN NAME Ella Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Hospital Records, Salisbury, Maryland	
17. INFORMANT Hospital Records, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerulonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 mo. Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30 , 19 58 , to August 3 , 19 58 , that I last saw the deceased alive on August 3 , 19 58 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Juerman		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 8/4/58	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral Aug 6-58		22b. DATE THEREOF Aug 6-58	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Bld		22d. LOCATION (City, town, or county) (State) Talbot Co	
23. FUNERAL DIRECTOR'S SIGNATURE Brook M. West		24a. REC'D BY REGISTRAR DATE Aug 11 58	
24b. REGISTRAR'S SIGNATURE Paul			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06. M. 11. 2. 4

FOR COMPLETION BY THE JURY OR COURT

PAID BOND

W. J. B. B. B.

STATE

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

REG. NO. 111

MADE IN

OF THE STATE OF

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

INTERVIEWED

BY

DATE

TIME

PLACE

CAUSE

INTERVIEWED

BY

DATE

TIME

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CAUSE

CERTIFICATE OF DEATH

Reg. Dist. No.

9630

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 yr.10mo.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury							
d. NAME OF HOSPITAL (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS 206 Center St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle REVEL Last SULLIVAN				4. DATE OF DEATH Month AUGUST Day 8th Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb.15,1868		9. AGE (In years last birthday) yrs. 90	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Revel				14. MOTHER'S MAIDEN NAME Dolly Willing			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address Mrs. John Sullivan (Daughter-In-Law) 206 Center St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 days Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10, 1956 to August 8th, 1958 , that I last saw the deceased alive on August 8th, 1958 , and that death occurred at 9:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 8/8/58							
ACTUAL SIGNATURE L.V. Maldve		M.D. Deer's Head State Hospital					
PHYSICIAN'S NAME (Type) L.V. Maldve, M.D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug.10,1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR AUG 12 1958	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove early papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9631

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN TB <u>8 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R. F. D. #2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH S. TAYLOR</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 20 19 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-14-9751</u>	
17. INFORMANT Address <u>REV. ANGELO H. BROWN, STOCKTON, M.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-13/</u> , 19 <u>58</u> , to <u>8/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/20/</u> , 19 <u>58</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u>		M.D. <u>Salisbury, Md.</u> DATE SIGNED <u>8-22-58</u>	
PHYSICIAN'S NAME (Type) <u>William R. Ellis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE BAPTIST</u>	22d. LOCATION (City, town, or county) (State) <u>RURAL STOCKTON, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>		ADDRESS <u>Pocomoke, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1073

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

<p>NAME OF DECEASED</p>	
<p>AGE</p>	
<p>SEX</p>	
<p>RACE</p>	
<p>DATE OF DEATH</p>	
<p>PLACE OF DEATH</p>	
<p>Cause of Death</p>	
<p>Signature of Physician</p>	
<p>Signature of Registrar</p>	

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9632
CERTIFICATE OF DEATH

10729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN 1b 12 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 SALISBURY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 82 PENINSULA GENERAL HOSPITAL		d. STREET ADDRESS 1 705 W. MAIN ST.	
3. NAME OF DECEASED (Type or print) LILLIE		4. DATE OF DEATH Month AUGUST Day 29 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Lillie Sipton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 164X	
17. INFORMANT Bettie Neal		Address 205 W. Main St. Salis. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 164X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Mediastinal Carcinoma (with Pulmonary Hemorrhage)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David F. Schore		ADDRESS (Street, city or town, state) Salisbury Md.	
PHYSICIAN'S NAME (Type) David F. Schore		DATE SIGNED Aug. 30, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sep. 8, 58	
22c. NAME OF CEMETERY OR CREMATORY green acres		22d. LOCATION (City, town, or county) (State) Salisbury Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart		ADDRESS Salis. Md.	
24a. REC'D BY REGISTRAR SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital				d. STREET ADDRESS 202 Naylor St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOUIS		Middle GLEN		Last TOWERS		4. DATE OF DEATH Month AUGUST Day 15th Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1885		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Line Foreman-C. & P. Telephone		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Preston, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. Towers				14. MOTHER'S MAIDEN NAME Pauline Burkett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. E. Pearl Towers (Wife) 202 Naylor St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11/58 to 8/19/58 , that I last saw the deceased alive on 8/11/58 , 19 58 , and that death occurred at 7:30 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED August 12, 1958							
ACTUAL SIGNATURE Dr. Fred R. Gramse				M.D. _____			
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse				402 S. Division St. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>BELLE</u> Last <u>Webster</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SOREN H. WEBSTER</u>		14. MOTHER'S MAIDEN NAME <u>WILLIE FIELDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>PLUMA CROPPER-DELMAR-MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular Accident</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Ruptured vessel in left hand & amputation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/3/58</u> , 19 <u>58</u> to <u>8/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-17-58</u> , 19 <u>58</u> , and that death occurred at <u>5:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Webster</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-19-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DEAL ISLAND</u>	22d. LOCATION (City, town, or county) (State) <u>DEAL ISLAND, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar Del</u>		24a. REC'D BY REGISTRAR <u>AUG 20 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9635

CERTIFICATE OF DEATH

09637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
c. LENGTH OF STAY IN 1b <u>8 DAYS</u>				d. STREET ADDRESS <u>709 Race Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clinton JAMES White</u>				4. DATE OF DEATH Month Day Year <u>August 1 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 12 1901</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDING (PROPRIETOR) WELDING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>LARRY T. WHITE</u>				14. MOTHER'S MAIDEN NAME <u>EMMA TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>ALICE P. WHITE-CAMBRIDGE, MD</u>			
17. INFORMANT Address <u>ALICE P. WHITE-CAMBRIDGE, MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>8 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 25 1958</u> to <u>August 1 1958</u> , that I last saw the deceased alive on <u>August 1 1958</u> , and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Kelly M.D.</u>				ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury Maryland</u>			
DATE SIGNED <u>8/1/58</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>AUG 3, 1958</u>		<u>ODD FELLOWS Cem.</u>		<u>SEAFORD, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Medford L. Watson Jr.</u>				ADDRESS <u>SEAFORD DEL</u>			
24a. REC'D BY REGISTRAR <u>DATAUG 4 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Reese Smith</u>			

MEDICAL CERTIFICATION

9636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>10 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Creek</u> <u>09X-2</u>			
f. STREET ADDRESS <u>NONE</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Solomon</u> Middle <u>R</u> Last <u>Willey</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/8/1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Willey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Foxwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Deer's Head Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor pulmonale</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bronchial pneumonia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General arteriosclerosis; right hemiplegia, aortic stenosis.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 27</u> , 19 <u>58</u> , to <u>Aug. 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 6</u> , 19 <u>58</u> , and that death occurred at <u>10:25 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Deer's Head State Hospital</u> <u>8/6/58</u>							
ACTUAL SIGNATURE <u>G. Kosmahly</u> M.D. <u>Deer's Head State Hospital</u> <u>8/6/58</u>							
PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Madison, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the registrar, it must be completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove cards, pins. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09639

9637

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u> <u>RR #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp</u>		d. STREET ADDRESS <u>Allen Road Route # 1.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Beulah Mae Williams</u>		4. DATE OF DEATH <u>August 22 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6. 1921</u>
9. AGE (In years, months, days) <u>37</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Worcester Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emily Ennis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Mary E Williams (Mother)</u>		<u>Route # 1. Salisbury, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia (Bacteremia)</u> <u>376X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cellulitis Left Eye</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 22, 1958</u> , to <u>August 22, 1958</u> , that I last saw the deceased alive on <u>August 22, 1958</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>8/23/58</u>	
ACTUAL SIGNATURE <u>Thomas C. Hill</u> M.D.		PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 26. 58.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smullen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Worcester County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co. Salisbury, Maryland.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

PREPARED BY

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF MOTHER

NAME OF FATHER

NAME OF SISTER

NAME OF BROTHER

NAME OF NEPHEW

NAME OF Nephew

NAME OF AUNT

NAME OF UNCLE

NAME OF Cousin

NAME OF GRANDFATHER

NAME OF GRANDMOTHER

NAME OF GRANDFATHER

NAME OF GRANDMOTHER

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.F.D.#1</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Wyatt</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD/R.F.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MINOS WYATT</u>		14. MOTHER'S MAIDEN NAME <u>LAURA WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>222-01-6834</u>	
17. INFORMANT <u>MRS. W. H. WYATT</u>		Address <u>OCEAN CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Carcinoma (Squamous Cell) of lung</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 mos</u> ⁺		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>Aug 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 14</u> , 19 <u>58</u> , and that death occurred at <u>11:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF RD</u> DATE SIGNED <u>8/16/58</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		<u>SALISBURY, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Bubbe</u> ADDRESS <u>Berlin md</u>		24a. REC'D BY REGISTRAR <u>Aug 20 58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 100

1932

DATE OF DEATH

DECEASED'S NAME

SEX

AGE

DATE

TIME

PLACE

CAUSE

MANNER

REPORTED BY

SIGNATURE

PRINTED NAME

ADDRESS

CITY

STATE

COUNTY

ZIP

FILE NO.

DATE

TIME



DEPARTMENT OF HEALTH - BALTIMORE 12

9639

CERTIFICATE OF DEATH

Reg. Dist. No. 09641

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle ZIMMERMAN Last		4. DATE OF DEATH Month Aug. Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 4 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Own Barber Shop	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT C.G. Messick, Bivalve, Maryland		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of rectosigmoid DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/17, 1958 , to 8/21, 1958 , that I last saw the deceased alive on 8/21, 1958 , and that death occurred at M , from the causes and on the date stated above.	
ACTUAL SIGNATURE William H. Fisher M.D. Salisbury, Md.	DATE SIGNED 8-27-58
PHYSICIAN'S NAME (Type) William H. Fisher Medical Center, Salisbury, Md. 8/23/58	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/23/58	22c. NAME OF CEMETERY OR CREMATORY Turner's Cem.	22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. G. Messick , Bivalve, Maryland		24a. REC'D BY REGISTRAR DATE SEP 9 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon 3 and 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

